



**STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
YOUTH COMMUNITY CORRECTIONS
FOSTER CARE MEDICAID REQUEST**

To: DPHHS IV-E Unit
Child & Family Services
P.O. Box 8005
Helena, MT 59620

From: (Placing worker)

Montana Department of Corrections

Address: , MT

Phone: (406)

YOUTH INFORMATION

Name: _____ SSN _____ - - _____ DOB _____
CAPS ID: _____ U.S. Citizen ☐ Yes ☐ No
Beginning Date of Placement: _____

PROVIDER INFORMATION

Name _____ CAPS Number _____ -
Address _____
City _____ State _____ Zip _____
Phone () - _____

YOUTH'S INCOME

Is the youth employed? ☐ Yes ☐ No

Name of Employer: _____

Rate of Pay: _____ Hours per week: _____

THIRD PARTY LIABILITY

Is the youth covered by **medical insurance**? ☐ Yes ☐ No

(If yes, provide copy of insurance card)

Is the youth covered by **life insurance**? ☐ Yes ☐ No

(If yes, provide documentation)

Attached:

- ☐ Birth Certificate
- ☐ YMS basic information sheet or school identification card with photo
- ☐ Copy of insurance card if youth is insured under parental insurance
- ☐ Form: YCC 60-25 (C), Youth Financial Status Report